Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RAYMOND GLASS DC
3100 TIMMONS LANE #250
HOUSTON TX 77027

Respondent Name
OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box
Number 44

MFDR Tracking Number
M4-13-0605-01

MFDR Date Received
August 21, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…In my review of this claim, I find that it was not reimbursed per the Commissioners bulletin #B-0044-11, of which I have attached a copy for your review. At this time, I am requesting that this claim be reviewed once again and the additional reimbursement be made."

Amount in Dispute: $44.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2012	97750-FC	$ 44.16	$25.53

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets forth the medical fee guideline for specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits (EOB)
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Issues

1. Did the requestor receive the correct reimbursement for a Functional Capacity Evaluation (FCE)?

Findings

1. An FCE is billed and reimbursed in accordance with 28 Texas Administrative Code §134.203(c)(1); however, an FCE is a Division-specific code with a Division-specific modifier (97750-FC). Therefore, the FCE is not subject to the Medicare payment provision of a multiple procedure payment reduction for selected therapy services. Additional reimbursement is recommended as follows:

(DWC conversion factor of $54.86 divided by Medicare conversion factor of $34.0376 x participating amount of $31.82 (locality 28, Fort Worth) = $51.29 x 16 units = $820.57 (MAR) minus respondent's previous payment of $795.04 = $25.53. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $25.53.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $25.53 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution	March , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.